

# ▶ Reimbursement Request Form

Employer Name: **University of Rochester**

Participant Name (First, MI, Last): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claimant Name	Date of Service	Amount	Plan Code*	Type of Service/Item Purchased	# of Miles	Claim Ref #
<i>John Sample</i>	<i>10/1/2014</i>	<i>\$ 150.25</i>	<i>F</i>	<i>Doctor visit copay</i>	<i>12</i>	<i>Example</i>
		\$				01
		\$				02
		\$				03
		\$				04
		\$				05
		\$				06
		\$				07
		\$				08
		\$				09
		\$				10
		\$				11
		\$				12

*Plan Code	Plan Code Description
F	Flexible Spending Account (FSA)
L	Limited Purpose Flexible Spending Account (LPFSA)

**Participant Authorization**—By submitting this form to Lifetime Benefit Solutions, I certify that the information here is true and correct.

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I have read the Reimbursement Request Instructions on the following page and agree to adhere to all terms specified. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 211126 Eagan, MN 55121 or
- **Fax to:** 877-256-7228.
- Call **Customer Service** with questions at 866-634-6508.



# Reimbursement Request Instructions

## For All Account Types (FSA, HRA, Parking/Transit, RRA, Insurance Premium)

- For faster reimbursement processing you may be able to submit your claims online at [www.lifetimebenefitsolutions.com](http://www.lifetimebenefitsolutions.com).
- Complete the top section, including Social Security Number or Employee ID.
- Submit one expense (either a product or service) per row, even if items are contained on the same receipt.
- Label the receipts to correspond to the Claim Ref #.
- If you have more items than the form can accept, use additional forms.
- Do not “lump” or group items together or write See Attached.
- All claims are subject to deadlines, as defined in your Summary Plan Description (SPD).
- The expenses you submit must qualify as valid expenses under the terms of the Plan, and the claimant receiving the services must be a qualifying individual as defined in the Plan.
- Retain a copy of the Reimbursement Request Form and receipts for your own personal records
  
- Call Lifetime Benefit Solutions Customer Service with questions at (866) 634-6508 during standard week-day business hours.
  
- Mail OR fax (but not both!) completed form with required documentation to:  
**Lifetime Benefit Solutions Claims Dept.**  
**PO Box 211126**  
**Eagan, MN 55121**  
**Fax # (877) 256-7228**

## Reporting Medical Mileage

- Medical mileage rates are set by the IRS and can be applied to transportation primarily for and essential to medical care.
- Indicate the total number of miles incurred with each service provided (i.e. round trip miles to visit the doctor).
- Lifetime Benefit Solutions will apply the current mileage rate and include the mileage amount in your total reimbursement.
- You may be required to produce additional documentation for each mileage expense you claim.

## Medical Claims for FSA and LPFSA

- For each medical claim covered by your insurance carrier, submit an Explanation of Benefits (EOB). If your claims are not submitted to your insurance carrier, provide an itemized bill showing: date of service, provider name, patient name, charged amount, and description of services rendered.
- Do not send credit card receipts, original receipts or cancelled checks.

## Dependent Care Claims

- Please use the separate form titled Dependent Care Account Reimbursement Request Form.